



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH  
COMMISSIONER

BILL HASLAM  
GOVERNOR

July 15, 2015

RECEIVED

Ms. Deborah Loveless, CPA, Director  
Division of State Audit  
Suite 1500, James K. Polk Building  
505 Deaderick Street  
Nashville, Tennessee 37243-1402

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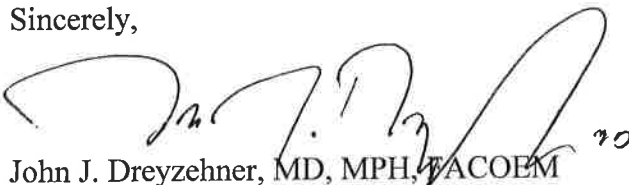
STATE AUDIT

Dear Ms. Loveless:

Attached is the status report of the actions taken by the Department of Health to correct the audit findings identified in the November 2014 Performance Audit conducted by your department. This status report is compiled in response to *Tennessee Code Annotated* Section 8-4-109(b).

Should you have questions concerning this status report please contact Mike Gaines at (615) 532-5042 or my office at (615) 741-3111.

Sincerely,



John J. Dreyzehner, MD, MPH, FACOEM  
Commissioner

Attachment

cc: Karen Cline-Parhamovich, DO – State Chief Medical Examiner  
Mike Gaines, Assistant Commissioner, Office of Compliance  
Jeff Spalding, Executive Director, Fiscal Review Committee

JJD/MG/ts

# TENNESSEE DEPARTMENT OF HEALTH

2014 PERFORMANCE AUDIT  
6 MONTH FOLLOW-UP  
July 15, 2015

## DEPARTMENT OF HEALTH AND THE MEDICAL EXAMINER ADVISORY COUNCIL

1. **Finding:** The Office of the Chief Medical Examiner has not provided a systematic training program for local officials, amid concerns of inconsistencies within the statewide system.

**Original Management Response:** We concur. The Office of the Chief Medical Examiner (OCME) recognizes the need for systematic training and has been taking steps to work within our staffing and budgetary constraints to provide training. OCME has applied for, and has been awarded, approximately \$155,000 in federal grants for training efforts.

The OCME office consists of one full-time state chief medical examiner and one full-time chief of operations. Three months ago, through grant funding, TDH hired one state medicolegal death investigator. This position is shared with Tennessee Department of Health Emergency Preparedness Program and is responsible for education and training of medicolegal death investigators across the state. OCME requests assistance from the regional forensic centers to assist in educational efforts. Between July 2012 and present, the state chief medical examiner has personally delivered lectures to nineteen (19) state and regional stakeholders in the death investigation system. There are three part-time subcontracted deputy state chief medical examiners, one for each grand division that assists in educational efforts.

OCME acknowledges that the training needs of the state require a multifaceted approach. OCME conducted a two day strategic planning retreat with leadership of the Regional Forensic Centers following appointment of the new State Chief Medical Examiner. Ideas and topics for statewide training were discussed and a general agreement to design a training plan after a statewide data collection system was enacted. The current educational plan for OCME consists of a combination of grant-funded seminars and in-person training. Since September 2014, the state medicolegal death investigator has conducted or is in the process of arranging training for four counties. OCME has consulted with two counties interested in improving the death investigation system in their county.

**Corrective Actions To Date:** We concurred. A multifaceted approach is outlined below.

**Training:** At the time of the audit, through grant funding, TDH hired one state medicolegal death investigator. In December 2014 the state medicolegal death investigator resigned, but is sporadically available to assist on a voluntary basis. The grant funds for the position were discontinued the following month. In the six months following the audit the OCME

conducted three trainings in the Eastern District through Justice Assistance Grant (JAG) funds. The trainings were successful, and imperative for the development of training for the next fiscal year of the JAG funds. In the upcoming fiscal year the OCME will be conducting ten training seminars across the state (1.5 days per seminar). Because of budgetary and travel limitations many counties face and the complexity of the training that must be offered the OCME has developed a different training technique that will be hands-on, constant involvement the entire day and facilitate communication and cooperation within their communities of county law enforcement and medical examiner investigation. Approximately 74 death investigators, law enforcement personnel and medical examiners were trained in the first three JAG trainings, with an expected outcome of an additional 320 attendees in the upcoming fiscal year of JAG trainings. During the last stakeholder meeting with the Regional Forensic Centers (RFC) the consensus was that consistency across the state not only takes training, but agreement and unity of all five forensic centers in tandem with the OCME efforts. The legislation that is discussed below included a \$500,000 budget item to establish annual training and continuing education for the medicolegal death investigators.

Equipment: In addition to training, the OCME observed the lack of proper equipment to assist in performance of optimal death investigation. In the time since the audit, through three separate federal grants, OCME distributed or is in the process of distributing approximately 87 child death investigation kits (includes a camera, laptop and death investigation doll), 27 death investigation kits (camera, laptop) and 46 death investigation dolls. Persons in all 95 counties were invited to apply for these supplies and equipment items and 160 individuals who either applied or attended training received materials. These 160 individuals represented 77 counties and all who applied received equipment or supplies.

Legislative Reform: The OCME recognized the need for statute reform and an Administration Bill was introduced this past session to update and improve the Post-Mortem Examination Act and at the same time address the issues noted in the NAME report. However, that legislation was not well received by many stakeholders. The Department agreed not to move forward with the legislative proposal in its current form in order to address all stakeholder concerns starting with the RFCs. The RFCs are composed of two centers run by universities, two centers run by their respective counties, and one center run by a private contracting company. Through a series of meetings with all five RFCs together, starting in April 2015, progress is being made which is needed to facilitate the OCME to reach out to the other stakeholders; for example State Representatives, County Mayors and Executives, District Attorneys General, etc. It is expected that legislation will be reintroduced in the upcoming legislative session.

Case Management: The OCME spent over one year reviewing case management systems best suited for the state, six months procuring the license for an open-source case management software, and the past ten months developing the case management system to be used statewide. The establishment of a case management system will establish uniformity across the state, regardless of county lines, and collate all data collected to produce state reports that provide critical statistics on public health and safety of all citizens and visitors of the state. Recently the company contracted to run one of the forensic centers in the state informed the OCME that they were interested in the state using their proprietary case

management system at a comparable cost to the open-source system the OCME already acquired. To determine the best suited case management system for the state, a group has been established to review both systems and make a recommendation to the OCME as to which case management system meets the needs of the state. The Central Procurement Office has tentatively arranged for the vendors to demonstrate their systems to the review group on July 29, 2015, and a decision on the system to be utilized should be made by the end of August 2015.

2. **Finding:** The Medical Examiner Advisory Council failed to meet statutory requirements.

**Original Management Response:** We concur. Once the vacancies on the Council are filled, it is the Department's intention to guide the Council toward at least an annual meeting which would meet the statutory requirements. At the next Council meeting we will ensure that each member completes a conflict-of-interest statement and those statements are properly filed. In addition, the Council will be asked to work with the chief medical examiner and the three Deputy State Chief Medical Examiners to develop and update guidelines for death investigations. These updated guidelines will be used to assist with the completion of the annual report on death investigations per the statutory requirements.

**Corrective Actions To Date:** We concurred. The Regional Forensic Centers (RFC), the OCME, and one medical examiner from each grand division reviewed the current statutory requirements of the Medical Examiner Advisory Council (MEAC). That review highlighted the belief that the current requirements for council membership may not be optimal for developing guidelines for the medical examiner system. The OCME is currently working with the chair of the MEAC, as well as the five forensic centers, to determine the roles best suited to develop a council that can accomplish the goals of the statute.